

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 22 1960

318

1003

6906

-60-028862

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

ENDED

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|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 84 years | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4121 Magnolia | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First FRED Middle WILLIAM Last TEPE | | | | 4. DATE OF DEATH Month July Day 7 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 4, 1876 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bricklayer | | | 10b. KIND OF BUSINESS OR INDUSTRY Building | | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME William Tepe | | | 13b. MOTHER'S MAIDEN NAME Marie Junge | | | 14. NAME OF HUSBAND OR WIFE Anna Dehling Tepe | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish-American | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Ida Thilking, 4121 Magnolia Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute right hemiplegia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) general arterio sclerosis | | | | Interval 2 yrs. | |
| | | DUE TO (c) Heart Block | | | | Interval 8 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 433.0 | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | Month, Day, Year | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from Jan 14, '60 to July 7, '60 and last saw him alive on 7/7/60 . Death occurred at 12 Noon m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Eugene A Vogel M.D. | | | | 22b. ADDRESS 3325 S Grand Pl | | 22c. DATE SIGNED 7/8/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE July 11, 1960 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H.Inc., 1936 St. Louis | | | 25. DATE RECD. BY LOCAL REG. JUL 11 1960 | | 26. REGISTRAR'S SIGNATURE Loan Smith M.D. | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mrc

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Homer W. Jutz

Licensed Embalmer No. 3882

P. O. Address St. Louis

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.